

# Maintaining communication in dementia

Staff and family members often report growing difficulties in communication when an individual experiences symptoms of dementia. There may have always been language and communication difficulties associated with the existing intellectual disability; these tend to become more prominent in dementia. The occurrence of problem behaviours such as aggression and wandering often further exacerbate concerns. Difficulties in coping with these behaviours and the potential embarrassment that can occur in front of others (particularly for family members), coupled with the diminished capacity of the person with dementia to engage in conversation, make it difficult to continue and conduct meaningful and satisfying interactions. This often leads to frustration, reduced visitations, and inappropriate interactions with the individual with dementia.

Yet, there is also evidence that the pattern of interaction between staff and family members and persons with dementia may positively influence the extent and level of problem behaviours and that assisting staff and families to reduce critical and angry responses and to structure interactions in a more supportive fashion has a positive impact on problem behaviours (McCallion *et al.* 1999). Good intentions and efforts to maintain communication on the part of staff and family members are often thwarted by poor understanding of the progression of dementia and by a lack of tools to respond more effectively. There is also such an emphasis on the declines associated with dementia that a sense of remaining strengths may be lost and with it the value of continued efforts to support communication. It is important therefore to recognise that there is research evidence with the general population (McCallion *et al.* 1999) for the efficacy and value of efforts to maintain communication in dementia; approaches are now being implemented with persons with intellectual disabilities and dementia (McCallion 1999; McCallion and Janicki 2002). Staff and family members should be encouraged to incorporate these strategies in their day-to-day communications. The strategies include verbal and non-verbal communication techniques, memory aids and a variety of psychosocial interventions.

## Non-verbal techniques

Non-verbal techniques found to be effective include:

- ◆ Relaxing—Staff and family members should release their own emotions before interacting with the person with dementia by using a deep breathing relaxation technique. This helps an individual, without becoming anxious, frustrated, or annoyed, to be able to listen to and interact with the person with dementia even when they seem to make no sense, or behave in an irrational fashion.
- ◆ Maintaining eye contact.
- ◆ Using a clear, low, loving tone of voice.
- ◆ Touching—persons with dementia may have diminished visual and auditory acuity, so they often appreciate feeling the touch of another human being. Staff and family members may need to re-evaluate the individual's comfort level with touching.

## Verbal techniques

Certain verbal techniques also help to foster communication with persons with dementia:

- ◆ Being supportive and non-confrontational—use non-threatening words to build trust and avoid being critical of the person with dementia.
- ◆ Asking simple, concrete questions—break what is said down into simple, concrete questions to promote communication.

- ◆ Increasing time for responses—talk slowly, pause frequently, and repeat key phrases when conversing with a person with dementia because the person's reaction times are often greatly slowed.
- ◆ Structuring, focusing, and simplification—take more responsibility for structuring and focusing conversations to facilitate the individual's use of remaining cognitive and communication skills, and to simplify instructions about tasks to remove demands that are now beyond the ability of the person with dementia.
- ◆ Encouraging and guiding—use verbal (and non-verbal) cues to encourage and stimulate the person with dementia to continue to communicate, and to guide the person through communication sequences and activities they are having trouble completing; help the person to continue to do things for themselves.
- ◆ Rephrasing and paraphrasing—repeat the person's basic message using the same key words, tone of voice, and cadence of speech. This encourages continued communication by enabling the person with dementia to hear what they said, by giving the person time to gather their thoughts in preparation for continuing the conversation, and to ensure that the message being conveyed is understood as intended.
- ◆ Reminiscing—encourage the person with dementia to explore and express pleasant memories from the past. Do not focus on the accuracy of these memories, but instead encourage persons with dementia to express themselves.
- ◆ Ambiguity—accept words that have no meaning to others, and respond by using ambiguous or vague terms in responses to such words so that communication with the person with dementia can be maintained. For example, in response to 'The quark shouted at me,' one might respond, 'He did! What happened next?'
- ◆ Identifying the preferred sense—if the person with dementia repeatedly communicates by using visual images such as 'I see it over there. It makes me nervous,' respond with simple questions such as 'What else do you see, what colour is it?' which encourages the person to use the preferred sense, sight.
- ◆ Linking the behaviour with the unmet human need—persons with dementia express basic needs through their behaviours; identify and respond to these needs. Is the person hot, cold, lonely, uncomfortable?

## Memory Aids

Personal Memory Albums are small photo albums that can be bought in local shops with easily turned pages. Place a photograph of a key memory on one page and a short statement about that memory on the page next to it. Personal Memory Charts use the same types of photographs and statements and are large, laminated, pieces of cardboard posted on the person's bedroom walls at a height suitable for the person who is ambulatory or who spends most of the day in a wheelchair. Albums or charts are designed to promote positive interactions and to focus on maintaining previously-learned information rather than imparting new information. The memory items address: (1) facts that are important to the person with dementia, (2) information on conversation topics the person likes or wants to talk about, and (3) facts that the person often gets confused.

To address *facts that are important* to the person with dementia, information in a Personal Memory Album or Chart might include: (1) the person—name, age, place of birth, what

they work(ed) at; (2) the person's family—names of family members and their relationship to the person with dementia; (3) the person's daily life—days and times for important events; (4) people the person with dementia now lives with—names of roommates, other people in the home or where they go to programmes.

Under *conversation topics*, staff and family members are encouraged to identify three topics that the person with dementia likes or wants to talk about. These topics may be from the person's current life or from her/his past. Topics that the person him/herself continues to attempt to discuss are preferred.

The individual's *forgetfulness of key facts* often makes communication difficult. To limit the impact of forgetfulness and confusion, key daily and weekly events such as meals, appointments, and family visits are often included in the Personal Memory Album or Chart.

### Psychosocial interventions

There are other tools, psychosocial interventions, available for staff and family members that have at least some research evidence to support their use with persons with dementia; tools that build upon efforts by staff and family carers to communicate more effectively. These tools include:

- ◆ Reminiscence therapy: more than the simple revisiting of the past, reminiscence therapy encourages reflection, reviewing of key life events and remembrance of associated emotions. There is evidence for its helpfulness in reducing symptoms of depression (Hsieh and Wang 2003).
- ◆ Validation Therapy: a therapy for communicating with old people with dementia who are often struggling to resolve unfinished business in their lives and relationships before they die (Feil 1993). It is based upon an attitude of respect and empathy, views retrieval of the past as healing and functional, and builds a trusting relationship between the carer and the person with dementia. There is controlled study evidence with nursing home populations for reductions in symptoms of depression and physically and verbally aggressive behaviours (Toseland *et al.* 1997).
- ◆ Leisure/Recreation/Activity Programs: The continuation of enjoyed activities and the adaptation of activities to reflect the impact of increased impairment are recommended. The emphasis must begin with the person themselves, on what works for the individual, reflects their likes and dislikes, strengths and needs and their unique life story and personality. There is controlled study evidence for persons with dementia for activity programmes reducing verbally aggressive behaviours, wandering/pacing (Toseland *et al.* 1997).
- ◆ Aromatherapy: Aromatherapy can be defined as the art and science of utilising naturally extracted aromatic essences from plants to balance, harmonise and promote the health of body, mind and spirit. It seeks to explore the physiological, psychological and spiritual realm of the individual's response to aromatic extracts as well as to observe and enhance the individual's innate healing process. Controlled study evidence has been reported for the effectiveness of lemon balm use for persons with dementia in reducing challenging behaviours and increasing quality of life (Ballard *et al.* 2002).
- ◆ Horticulture Therapy: Utilisation of a variety of activities related to plants, gardening, flower presentation, and nature exploration relying upon hands-on planting and care, viewing, touching and discussing plant and garden issues and enjoying indoor and outdoor activities including greenhouses, nature walks, flowerboxes, flowerbeds and vegetable plots. There are anecdotal and single-subject design evidence for reductions in sleep disturbance and increases in pleasurable interactions.

- ◆ Music Therapy: Music therapy consists of using music therapeutically to address physical, psychological, cognitive and/or social functioning of persons with dementia. Music is a form of sensory stimulation, which provokes responses due to the familiarity, predictability, and feelings of security associated with it. Use of instruments, singing, listening to and discussing music are all related activities. There is evidence (some from controlled studies) for music therapy resulting in reductions for persons with dementia in challenging behaviours and increases in social participation (Koger, Chapin and Brotons 1999).
- ◆ Snoozelen: Snoozelen environments increase the amount of sensory stimulation by using lava and fibre optic lamps to provide changing visual stimulation, pleasant aromas, gentle music, and various materials of interesting textures to touch and feel. Pleasurable sensory experiences are arranged to stimulate the primary senses without the need for intellectual activity in an atmosphere of trust and relaxation. It is also a failure-free approach with no pressure to achieve. Controlled study evidence has been reported after use of Snoozelen in persons with dementia of reductions in socially disturbed behaviours and increases in communication (Baker *et al.* 1997).

### Conclusion

The important message for staff and family carers is that, while there has as yet been little research effort to test the effectiveness of the interventions recommended here for persons with ID and dementia, these are all activities which have been used for years with great effect with persons with ID. Staff and family carers actually know a lot about what can be done and what can be effective; their most potent strength is how well they know the individual with dementia. More work clearly needs to be done on testing the effectiveness of these strategies and in developing manuals to guide staff and family carers. In the meantime staff and family carers should use the approaches they know, rely upon their knowledge of and their relationship with the individual, and focus upon what they and the person with dementia still remember and value rather than on what is being lost.

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### References

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